



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

RAYMOND KWONG, MD

Respondent Name

AMERICAN ZURICH INSURANCE CO

MFDR Tracking Number

M4-13-3429-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

AUGUST 26, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The disputed service is a Commissioner ordered Designated Doctor evaluation. The service was performed and billed in accordance with the Texas Department of Insurance Fee Schedule for CPT code 97750FC."

Amount in Dispute: \$648.64

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Per Sedgwick Bill Review regarding the FCE charge, it was denied because of the 97750 code, as the edit is not going to be allowed because it is going to be bundled within the 99456 code submitted for \$1,300. In other words, the provider cannot bill the 97750 and the 99456 together even though they submitted on two separate bills, because the tax ID number will show the two codes being billed together, and the same doctor is listed on the bills."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 6, 2013	CPT Code 97750-FC (16 units) Functional Capacity Evaluation (FCE)	\$648.64	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 and §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 97-Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

- 906-In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code Editor), component code of comprehensive medicine, evaluation and management services procedure (90000-99999) has been disallowed.
- OA-The amount adjusted is due to bundling or unbundling of services.

Issues

1. Is the allowance of code 97750FC included in the allowance of another service/procedure rendered on the disputed date?
2. Is the requestor entitled to reimbursement for the functional capacity evaluation rendered on April 6, 2013?

Findings

1. The respondent contends that reimbursement is not due for code 97750FC because "it is going to be bundled within the 99456 code submitted for \$1,300."

28 Texas Administrative Code §134.204(j)(3)(C) regarding a designated doctor examination that "An examining doctor, other than the treating doctor, shall bill using CPT Code 99456."

28 Texas Administrative Code §134.204(j)(5) states "If the examination for the determination of MMI and/or the assignment of IR requires testing that is not outlined in the AMA Guides, the appropriate CPT code(s) shall be billed and reimbursed in addition to the fees outlined in paragraphs (3) and (4) of this subsection." The respondent did not submit documentation to support that the testing is outlined in the AMA guides as inclusive to the MMI/IR exam; therefore, the respondent's denial based upon reason code "97" is not supported.

2. 28 Texas Administrative Code §134.204(g) states "The following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required. FCEs shall include the following elements:

(1) A physical examination and neurological evaluation, which include the following:

- (A) appearance (observational and palpation);
- (B) flexibility of the extremity joint or spinal region (usually observational);
- (C) posture and deformities;
- (D) vascular integrity;
- (E) neurological tests to detect sensory deficit;
- (F) myotomal strength to detect gross motor deficit; and
- (G) reflexes to detect neurological reflex symmetry.

(2) A physical capacity evaluation of the injured area, which includes the following:

- (A) range of motion (quantitative measurements using appropriate devices) of the injured joint or region; and
- (B) strength/endurance (quantitative measures using accurate devices) with comparison to contralateral side or normative database. This testing may include isometric, isokinetic, or isoinertial devices in one or more planes.

(3) Functional abilities tests, which include the following:

- (A) activities of daily living (standardized tests of generic functional tasks such as pushing, pulling, kneeling, squatting, carrying, and climbing);
- (B) hand function tests that measure fine and gross motor coordination, grip strength, pinch strength, and manipulation tests using measuring devices;
- (C) submaximal cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill; and
- (D) static positional tolerance (observational determination of tolerance for sitting or standing)."

CPT code 97750 is defined as "Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes." CPT code 97750 requires direct one-on-one patient contact.

A review of the submitted Functional Capacity Evaluation report indicates "Total Test/Report Time: 9:28am-1:37pm."

The Division finds that the Functional Capacity Evaluation report noted the four hours that were billed by the requestor; however, it does not comply with the billing requirements for CPT code 97750 because it did not

indicate the amount of time that was actually spent testing. The requestor noted that FCE time included "Report Time" that are services not related to direct one-on one time. In addition, the requestor did not document key elements required by 28 Texas Administrative Code §134.204(g)(1-2). Therefore, the Division concludes that the requestor has not supported billing the four hours of service or FCE. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	07/10/2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.